# ISL BUDGET PLAN

INITIAL ☐ Service Coordinator: _____

COST INCREASE ☐ MW ELIGIBLE: YES: _____ NO: _____

COST DECREASE ☐ MEDICAID #: _____

SAME COST ☐ # PEOPLE SHARING HHOLD: _____

NAME: _____ ID#: _____

ADDRESS: _____

AUTHORIZATION DATES FROM: _____ TO: _____ IHP DATES FROM: _____ TO: _____

LEAD AGENCY:

## ROOM AND BOARD

| | Total Cost | Other | (Sources) | Remaining |
|---|---|---|---|---|
| FOOD | | | | |
| LAUNDRY | | | | |
| HOUSE SUPP | | | | |
| RENT | | | | |
| UTILITIES | | | | |
| PHONE | | | | |
| CABLE TV | | | | |
| TRASH | | | | |
| WATER | | | | |
| OTHER: (List) | | | | |
| | | | | |
| | | | | |
| | | | | |

## RESIDENTIAL HABILITATION

MONTHLY AMOUNT

COMMUNITY SPECIALIST: _____ Hrs X $ _____ $

COMMUNITY INTEGRATION SKILLS TRAINER: _____ Hrs X $ _____ $

COMMUNITY INTEGRATION DIRECT SERVICE: _____ Hrs X $ _____ $

DIRECT SERVICE STAFF _____ Hrs X $ _____ $

STAFF MILEAGE 34 Cents X _____ $

OTHER: (LIST)

$

$

$

ADMIN - FIXED AMOUNT $

RN NURSE VISIT $

CASE COORDINATION FEE $

**TOTAL MONTHLY ROOM & BOARD** $ **TOTAL MONTHLY RES HAB** $

**TOTAL DAILY ROOM & BOARD** $ **TOTAL DAILY RES HAB** $

| PRS SPEND | PAYEE STATUS | PAYEE NAME/ADDRESS: |
|---|---|---|
| $ | DMH ☐ CONSUMER ☐ OTHER ☐ | |

**APPROVAL: I CERTIFY THIS INDIVIDUALIZED SUPPORTED LIVING RESIDENTIAL BUDGET PLAN IS NECESSARY AND REASONABLE TO IMPLEMENT THE PLAN AND HEREBY REQUEST APPROVAL.**

ISL PROVIDER: _____ DATE: _____

REGIONAL CENTER APPROVAL: _____ DATE: _____

Revised 9/16/2004